



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Jesse O. Schneringer, D.C.

**Respondent Name**

Atlantic Specialty Insurance Company

**MFDR Tracking Number**

M4-17-2227-01

**Carrier's Austin Representative**

Box Number 29

**MFDR Date Received**

March 22, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Reimbursement should have been \$350 for determination of MMI and \$300 for the calculation of impairment. Range of motion was measured according to AMA Guidelines and according to below code reimbursement should be \$300 for range of motion."

**Amount in Dispute:** \$650.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "This charge denied because an invalid code was submitted on the bill or the bill has missing or invalid required information ... 99456/W5 for MMI exam should be billed with modifier WP, 26, TC Since the provider did not bill appropriately bill is denied"

**Response Submitted by:** Gallagher Bassett

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2017	Designated Doctor Examination	\$650.00	\$650.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.240 sets out the billing requirements for designated doctor examinations performed on or after September 1, 2016.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on or after September 1, 2016.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
  - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

### Issues

1. Are Atlantic Specialty Insurance Company's reasons for denial of payment supported?
2. Is Jesse O. Schneringer, D.C. entitled to reimbursement for the disputed services?

### Findings

1. Dr. Schneringer is seeking reimbursement of \$650.00 for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating (IR) performed on January 10, 2017. Atlantic Specialty Insurance Company (Atlantic Specialty) denied the MMI portion of the examination with claim adjustment reason code 4 – "The procedure code is inconsistent with the modifier used or a required modifier is missing."

28 Texas Administrative Code §134.240(1)(B) states that designated doctor examinations to determine maximum medical improvement "shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier 'W5' is the first modifier to be applied when performed by a designated doctor."

28 Texas Administrative Code §134.250(3) states, in relevant part, that the "following applies for billing and reimbursement of an MMI evaluation ... (C) An examining doctor, other than the treating doctor, shall bill using CPT code 99456. Reimbursement shall be \$350."

The division concludes that no other modifiers are required for the MMI portion of the examination if the injured employee is deemed to be at MMI. Review of the submitted documentation finds that Dr. Schneringer billed the MMI portion of the examination with CPT code 99456 and modifier "W5" in accordance with 28 Texas Administrative Codes §§134.240(1)(B) and 134.250(3)(C). Atlantic Specialty's denial of payment for this examination is not supported.

Atlantic Specialty denied the IR portion of the examination with claim adjustment reason code 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication."

28 Texas Administrative Code §134.240(1)(A) states that designated doctor examinations to determine impairment rating "shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier 'W5' is the first modifier to be applied when performed by a designated doctor."

28 Texas Administrative Code §134.250(4) states, in relevant part, that the "following applies for billing and reimbursement of an IR evaluation. (A) The health care provider shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form." The division finds that the applicable MMI evaluation CPT code, as noted above, is 99456.

28 Texas Administrative Code §134.250(4)(C)(iii) states, in relevant part, that the following **applies to billing and reimbursement of an IR evaluation**, "If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP.' Reimbursement shall be 100 percent of the total MAR."

Review of the submitted documentation finds that Dr. Schneringer billed the IR portion of the examination with CPT code 99456 and modifiers "W5" and "WP" in accordance with 28 Texas Administrative Codes §§134.240(1)(A) and 134.250(4)(C)(iii). Atlantic Specialty's denial of payment for this examination is not supported.

2. The submitted documentation supports that Dr. Schneringer performed an evaluation of MMI. Therefore, the maximum allowable reimbursement (MAR) for this examination is \$350.00 in accordance with 28 Texas Administrative Code §134.250(3)(C).

28 Texas Administrative Code §134.250(4)(C)(ii) states that the MAR for musculoskeletal body areas is:

- (I) \$150 for each body area if the diagnosis related estimates (DRE) method found in the AMA Guides fourth edition is used.
- (II) If full physical evaluation, with range of motion, is performed:
  - (-a-) \$300 for the first musculoskeletal body area; and
  - (-b-) \$150 for each additional musculoskeletal body area.

The submitted documentation supports that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the left ankle. Therefore, the MAR for this examination is \$300.00.

The total MAR for the disputed services is \$650.00. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$650.00.

### ***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

### **Authorized Signature**

_____ Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	June 9, 2017 Date
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### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim. The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**